433.480: continued

(2) The recipient's physician will be expected to furnish program staff members, upon request, with the results of this physical examination; a list of current medications and treatments; any special dietary requirements; a statement indicating any contraindications or limitations to the individual's participation in program activities; and recommendations for therapy, when applicable.

(3) Each recipient's physician will receive a participant care plan developed by the staff members of the program for review every three months. The program's registered nurse will request that the participant care plan be reviewed and signed by the physician and returned to the program.

433.481: Alternatives to Institutional Care: Independent Living Programs

(A) Program Definition. Independent living programs teach persons with severe physical disabilities the skills to live independently, assisted by a personal care attendant. The skills may be taught in a group residential setting or individually. For those severely disabled persons who have the ability to train and manage a personal care attendant and who are living independently in the community, the program acts as a fiscal conduit to pay the personal care attendant. Participation in this program is helpful to persons to whom a lifetime of institutional or family care is unacceptable.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for independent living program services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Physician Responsibilities. The recipient's physician must certify that the recipient is:

(1) severely physically disabled (in need of an average of four hours or more of personal care attendant services per day);

(2) wheelchair dependent for mobility;

(3) emotionally stable; and

(4) medically stable (able to participate in daily living activities without requiring frequent substantial medical care).

433.482: Alternatives to Institutional Care: Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

(A) Program Definition. Community intermediate care facilities for the mentally retarded (or for persons with related conditions) are small community-based residential programs for 15 or fewer residents. There are two types of community ICFs/MR: Type A, serving participants not capable of self-preservation, and Type B, serving ambulatory and mobile nonambulatory participants capable of self-preservation. Both types of facilities provide a planned, 24-hour program of care to persons who are mentally retarded or developmentally disabled. A recipient who participates in a community ICF/MR must be in need of and capable of benefiting from active treatment (for example, a program of regular participation in accordance with an individual plan of care professionally developed and administered by an interdisciplinary team). Treatment is designed to increase the participant's level of functioning and to allow the participant to become as independent as possible. Participants must have the potential through active treatment to move eventually from the ICF/MR into a setting that is less restrictive.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8), the Division pays for ICF/MR services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), *see* 130 CMR 450.111.

433.482: continued

(C) Physician Responsibilities. The propriety of the recipient's placement in an ICF/MR must be certified by a physician at the time of the recipient's admission and recertified every 60 days. The Massachusetts Department of Mental Health regional or area office screens all potential ICF/MR residents. Physicians who believe that their patients are in need of ICF/MR services should contact the Department of Mental Health area office.

433.483: Alternatives to Institutional Care: Day Habilitation Centers

(A) Program Definition. Day habilitation centers serve persons who are mentally retarded and developmentally disabled and who need more habilitative services than are provided in less-restrictive day programs but who do not require full-time institutionalization. Day habilitation centers provide a range of intensive medical, behavioral, and therapeutic services in a culturally normative setting. The centers provide goal-oriented services that help participants reach their highest possible level of independent functioning and that facilitate the participants' moving to less-restrictive settings.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8), the Division pays for day habilitation services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

(C) Physician Responsibilities. The Division screens and refers potential recipients to day habilitation centers with the Massachusetts Department of Mental Health. Any physician who believes that his or her patient would benefit from day habilitation services should contact the Department of Mental Health area office.

433.484: The Massachusetts Special Education Law (Chapter 766)

(A) Requirement of Law. Chapter 766 of the Acts of 1972 is a comprehensive special education law that requires local school agencies to develop and implement individual educational plans for children with special needs. The law mandates that every child between the ages of three and 21 who has special needs should take part in a special education program. Any child entering kindergarten must have a comprehensive health and developmental examination. Any student between the ages of three and 21 who is having school-related problems will be referred to the school's Administrator of Special Education to obtain all necessary assessments, including medical, psychological, and other specialty evaluations. Based on the results of these assessments, an individualized educational plan will be developed with an emphasis on meeting the needs of the child within the regular classroom setting. In addition, any problems that have been diagnosed must receive treatment.

(B) Payment. Many of the evaluation and treatment services required by the Special Education Law are reimbursable under the Medical Assistance Program. The Division cannot pay for services provided by school personnel. Any services not furnished by Medical Assistance providers, such as educational and social services, that are necessary for an eligible child's special education, will be furnished or arranged for by the local school agency, as required under Chapter 766.

(1) Individual Medical Assistance Providers. The Division will pay providers for services mandated by the Special Education Law that are furnished to children who are recipients. Payment will be based on the existing fee schedules. For example, the Division will pay for a complete physical examination as required by the law for a kindergarten-aged child if the child is referred to a pediatrician or health clinic that participates in the Medical Assistance Program. As required by the law, a provider who performs any assessments of eligible children after referral by an Administrator of Special Education must submit the reports to the local school agency. The provider must also take the responsibility for treatment of detected conditions.

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(2) Medical Assistance Core Evaluation Groups. The Division will pay, at a comprehensive rate, Division-approved interdisciplinary professional groups and Division-approved medical facilities that perform the medical, psychological, and family assessments of a Chapter 766 full core evaluation.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 18, § 10; M.G.L. c. 118E, § 4.

(PAGES 483 THROUGH 488 ARE RESERVED FOR FUTURE USE).

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(2) Once a physician has submitted a claim for PGH services, his name and address will appear on a PGH referral list to be used by the Division unless the physician notifies the Division's Medical Division either that he wants his name removed from the PGH referral list or that he no longer intends to provide PGH services.

(C) Disclosure Requirement. Recipients must be informed by the physician that information about their medical care will be furnished to the Division.

433.488: Project Good Health Services: Medical Protocol and Periodicity Schedule

Payment for PGH services is based upon the performance and documentation of the procedures listed in the Medical Protocol and Periodicity Schedule herein. The Schedule provides for basic preventive care and identifies recipients who require further diagnosis of suspected or actual health problems, treatment, or both. Explanations of procedures that appear in the Schedule and the information that must be maintained in the medical record to substantiate the performance of such procedures appear below.

(A) (Newborn) Initial History and Physical Examination -- documenting either in the physician's medical record or in the hospital chart an examination of the newborn in the hospital.

(B) (Newborn) Discharge History and Physical Examination -- documenting either in the physician's medical record or in the hospital chart the discharge history and physical examination of the newborn in the hospital.

(C) Health History -- recording in the medical record the family health history, baseline data on the recipient if not recorded previously, growth and development history, immunization history, known reactions to medications and allergies, pertinent information about previous illnesses and hospitalizations, drug, alcohol, and tobacco use, and other medical and psychosocial problems.

(D) Comprehensive Physical Examination -- documenting the findings, negative or positive, of an unclothed physical examination including:

(1) height, weight, and head-circumference measurements: head-circumference measurements are required until age one and recommended until age two. It is also recommended that measurements be plotted on appropriate growth charts;
(2) interval history: updating previously collected history in the medical record with any illnesses, diseases, or medical problems experienced by the recipient since the last visit;
(3) systems review, pertinent to the age of the recipient;
(4) gross vision and hearing screening up to age three, including the combined observations by the recipient's parent or guardian and physician of the recipient's response to sound and ability to follow moving objects visually;
(5) observation of the teeth and gums as appropriate; and
(6) other pertinent findings of the examination.

(E) Developmental Assessment -- the combined observations by the recipient's parent or guardian and by the physician of the recipient's current levels of functioning in the following areas, as appropriate to the recipient's age:

(1) gross motor development, including strength, balance, and locomotion;
(2) fine motor development, including hand-eye coordination;
(3) language development, including expression, comprehension, and articulation;
(4) self-help and self-care skills;
(5) cognitive skills, including problem-solving and reasoning abilities;
(6) sexual development, using a measure such as the Tanner scale; and

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(7), mental/emotional development, including the presence of learning disabilities, social integration and peer relations, psychological problems such as depression, and assessment of risk-taking behavior and school performance.

Documentation of developmental assessment may include descriptive observations, milestones, and/or the results of specific developmental screening tests such as the Denver Prescreening Developmental Questionnaire (PDQ), the Denver Developmental Screening Test (DDST), or the Early Language Milestone Scale (ELM). (PGH recommends referrals to early intervention programs for eligible children as defined by the Massachusetts Department of Public Health.)

(F) Nutritional Assessment -- the evaluation of the recipient's nutritional health, which includes history, diet history, physical examination, height, weight, head-circumference measurements, and laboratory tests. (PGH recommends that a referral be made to the Women, Infants, and Children program (WIC) for all eligible recipients.)

(G) Immunization Assessment/Administration -- the assessment of immunization status and administration of serums in accordance with the recommendations of the Massachusetts Department of Public Health and the American Academy of Pediatrics.

(H) Blood Pressure -- a standard procedure of the physical examination for recipients three years of age or older.

(I) Hearing Test -- screening by an audioscope or audiometric testing by an audiometer at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz. If the hearing test is performed in another setting such as a school, the test does not need to be repeated by the physician, but the test findings should be documented in the recipient's medical record.

(J) Vision Test -- testing by the Snellen chart, Titmus machine, or equivalent. Other tests, such as the Preschool Vision Screening System and the Broken Wheel, may be appropriate for preschool-aged children. If the vision test is performed in another setting such as a school, the test does not need to be repeated by the physician, but the test findings should be documented in the recipient's medical record.

(K) Health Education and Counseling -- educating and counseling the recipient, or his parent or guardian, in matters appropriate to the recipient's age (for example, nutrition, growth and development, tobacco and drug use, sexuality, AIDS, safety, and accident prevention).

(L) EP or Blood Lead Test -- the erythrocyte protoporphyrin method of testing for lead poisoning and iron deficiency, or other method as recommended by the Massachusetts Department of Public Health (DPH). It is recommended that children at increased risk receive more frequent screenings (for example, screenings every four to six months between the ages of nine months and three years or as recommended by DPH).

(M) Urinalysis -- the recommended urine screen, with or without microscopy.

(N) Urine Culture -- the recommended screening of preschool-aged females for asymptomatic bacteriuria. Routine cultures on males are not recommended unless indicated by history and/or examination.

(O) Tuberculin Test -- testing by the Tine or Mantoux (PPD). It is recommended that children at increased risk receive more frequent screenings (for example, screenings every three years after the four- to-six-year screening or as recommended by DPH).

(P) Cholesterol -- children over age two must be screened if their medical history indicates risk (that is, family history of heart attacks at an early age, coronary disease, lipidemia, diabetes, etc.).

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(Q) Sickle Cell -- this test is required if indicated by ethnicity. The Division recommends rescreening and education during adolescence as indicated.

(R) Pelvic Examination/Pap Smear -- these are recommended depending on the maturity level and sexual activity of the recipient. Documentation shall include both normal and abnormal findings for the initial pelvic examination and any abnormalities found thereafter. The Pap smear should be done at the time of the pelvic examination.

(S) Screens for Sexually Transmitted Diseases: Gonorrhea, Syphilis, Chlamydia, or Others -- tests should be performed for males and females depending on the maturity level, sexual activity, and/or abuse history of the recipient. If indicated, these may be done earlier than age 14.

(T) Dental/Fluoride Assessment -- the screening physician must encourage recipients to seek regular dental care, including biannual examinations, preventive services, and treatment, as necessary, from a dental provider, and must perform an assessment of systemic and topical fluoride on all children, newborn to age 21 years, as appropriate.

(U) Dental Referral -- the screening physician must refer recipients to a dental provider at age three, or earlier if indicated (such as when nursing-bottle syndrome is present).

433.489: Project Good Health Services: Description of Health Assessments

The health assessments described in 130 CMR 433.489 are reimbursable when provided by a physician or by a physician assistant under a physician's supervision.

(A) Initial Visit/Complete PGH Assessment. A physician may claim payment using Service Code 9021 for an initial visit, which consists of a complete PGH assessment in the provider's office for a new patient, or for a patient previously seen only for sick care (only once per recipient). A complete assessment includes the recording of family, medical, developmental, and immunization history; a systems review; a comprehensive physical examination; and appropriate screening as indicated in the PGH Medical Protocol and Periodicity Schedule.

(B) PGH Health Assessment. A physician may claim payment using Service Code 9020 for a PGH health assessment only if all the screening procedures in the Medical Protocol and Periodicity Schedule that correspond to the recipient's age have been performed. While the screening procedures are based upon a presumption of regular contact with health-care providers, many recipients have infrequent attention paid to their health-care needs and will need additional screening procedures to bring them up-to-date. In such a case, it is the physician's responsibility to furnish those additional screening procedures necessary to bring the recipient up-to-date with the recipient's preventive health care according to the Medical Protocol and Periodicity Schedule. The physician may make a screening referral to another provider if the physician is unequipped to perform a test (for example, if the physician does not have an audiometer and an audiometric test is required). However, in every case, all required screening procedures must have been performed and all results received in order for the physician to claim payment for a PGH health assessment.

(C) PGH Health Assessment with Special Circumstances. A physician may claim payment using Service Code 9022 for a PGH health assessment with special circumstances only in the following situations: a screening procedure has been omitted from the health assessment; or the results of laboratory tests or other referred screening procedures were not available within 30 days (see 130 CMR 433.489(C)(1) and (2)). The Division will individually review all claims for PGH health assessments with special circumstances to determine whether payment will be made. All claims for such health assessments based on the omission of a medically unnecessary screening procedure will be reviewed.

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(1) Omission of a Procedure. A physician may omit a procedure from a health assessment only in the following situations.

(a) Procedure Was Not Medically Necessary. If a physician omits a screening procedure from a PGH health assessment because, in the physician's professional judgment, the procedure is not medically necessary, the physician must indicate on the PGH claim form which procedure is omitted and why it is not necessary (see the billing instructions in Subchapter 5 of the *Physician Manual*). If a procedure is omitted because it was performed earlier, the date the procedure was performed must be included in the explanation and the results recorded in the recipient's medical record. If a procedure is omitted because it was performed in school, the results must be included in the explanation and recorded in the recipient's medical record. For the purposes of 130 CMR 433.489, nonperformance of a recommended procedure in the Medical Protocol and Periodicity Schedule is not considered an omission. Nonperformance of a required procedure is considered an omission.

(b) Procedure Was Impossible to Perform. If a physician omits a screening procedure from a PGH health assessment because it is impossible to perform, the physician must indicate on the PGH claim form which procedure is omitted and why it cannot be performed (see Subchapter 5 of the *Physician Manual*). If the procedure is impossible to perform because the recipient refuses to cooperate, the physician must describe in the explanation efforts made to overcome the recipient's resistance.

(2) Results of Laboratory Test or Referral Screening Procedure Not Available within 30 Days. If a physician does not know the results of a laboratory test or referred screening procedure within 30 days after the health assessment, the physician must indicate on the PGH claim form which laboratory or test results have not been received.

433.491: Project Good Health Services: Diagnosis and Treatment

(A) For any problem that requires further diagnosis or treatment after the health assessment, the physician must either request that the recipient return for another appointment as soon as possible or make a referral immediately (or as soon as the physician obtains the screening result indicating a need for referral).

(B) When making a referral to another provider, the screening physician must give to the recipient or to the recipient's parent or guardian the name and address of an appropriate provider.

(C) The screening physician must obtain a report of the results of diagnosis and treatment.

(D) If a physician knows of any reason that a recipient might not make or keep an appointment for further diagnosis and treatment, such as a need for transportation or translation, the physician may contact the PGH specialist in his area for assistance. PGH specialists are located in the local welfare offices.

433.492: Project Good Health Services: Claims for Health Assessments

(A) Fees for Health Assessments. The fees for the PGH health assessments in Subchapter 6 of the *Physician Manual* were adopted by the Massachusetts Rate Setting Commission for PGH health assessments furnished in accordance with the Medical Protocol and Periodicity Schedule and with these PGH regulations.

(B) Service Limitations. For each recipient from birth through nine years of age, a physician may claim only one health assessment per age level in the Medical Protocol and Periodicity Schedule. For each recipient aged ten years through 20 years, a physician may claim only one health assessment per year. Additional visits for high-risk recipients are not considered to be PGH health assessments but are reimbursable according to the office visit service codes and descriptions in Subchapter 6 of the *Physician Manual*.

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(C) Claims for Health Assessment of a Newborn. In order to be paid for a PGH health assessment of a newborn, the physician must have visited the newborn at least twice before the newborn leaves the hospital. The first visit, for an initial history and physical examination, is reimbursable as a hospital inpatient visit (see Subchapter 6 of the *Physician Manual*) and not as a PGH health assessment. The discharge visit, for a discharge history and physical examination, is reimbursable as a PGH health assessment, in accordance with 130 CMR 433.49289(D). Additional visits for ill newborns are reimbursable according to the hospital visit service codes in Subchapter 6 of the *Physician Manual*.

(D) Report Requirement. In order to claim payment for a PGH health assessment, a physician must submit a completed PGH claim form. The PGH claim form is specifically designed for recording whether each required test and screening procedure was provided, and for indicating problems needing follow-up treatment. Instructions for obtaining and completing the PGH claim form are in Subchapter 5 of the *Physician Manual*.

(1) When submitting a claim for a health assessment with special circumstances, the physician must explain the special circumstances on the PGH claim form (see 130 CMR 433.489(C)).

(2) If a nurse practitioner or physician assistant has performed the health assessment, this must be indicated on the PGH claim form.

433.493: Project Good Health Services: Claims for Laboratory Services

The following laboratory services, which are included in the Medical Protocol and Periodicity Schedule, are reimbursable in addition to the health assessment when they are performed in the office of the physician who furnished the health assessment. A physician may not claim payment for any test until the results are known.

Service Code	Service Description
822310	Beta-2 microglobulin, urine; RIA
822320	Beta-2 microglobulin, serum; RIA
850180	Blood count; hemoglobin
850140	Blood count; hematocrit
862560	Chlamydia (fluorescent antibody; titer)
824650	Cholesterol, serum, total
870810	Culture, bacterial; screening only, for single organisms
871100	Culture, chlamydia (I.C.)
881500	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou); up to 3 smears; screening by technician under physician supervision
108379	Erythrocyte protoporphyrin; mailing of specimen to Department of Public Health
836550	Lead, blood; quantitative
836600	Lead, urine; quantitative
847030	Pregnancy test (gonadotropin, chorionic; qualitative)

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Service Code	Service Description
847020	Pregnancy test (gonadotropin, chorionic; quantitative)
872100	Smear, primary source, with interpretation; wet mount with simple stain, for bacteria, fungi, ova and/or parasites
865920	Syphilis; precipitation or flocculation tests, qualitative (VDRL, RPR, ART)
856600	Sickling of RBC; reduction, slide method
844780	Triglycerides, blood
810000	Urinalysis, routine (pH, specific gravity, protein, tests for reducing substances as glucose); with microscopy
810020	Urinalysis, routine; without microscopy

433.494: Project Good Health Services: Claims for Audiometric Hearing and Titmus Vision Tests

Payment for the audiometric hearing test and the Titmus vision test, which are both included in the Medical Protocol and Periodicity Schedule, is not included in the fee for a health assessment and should be claimed separately according to the service codes in Subchapter 6 of the *Physician Manual*.

433.495: Project Good Health Services: Recordkeeping Requirements

(A) Medical Records. A physician must create and maintain a centralized record for every PGH recipient in his care, in accordance with Division regulations governing medical records (see 130 CMR 433.409). In addition, the record for each PGH recipient must contain documentation of the screening procedures listed in 130 CMR 433.488(A) through (U) as well as the following:

(1) the results of all laboratory tests;
(2) the name and address of each referral provider; and
(3) the date and results of each referral appointment, if the appointment was kept.

(B) Determination of Compliance with Medical Standards. The Division may review a physician's medical records of PGH recipients to determine the necessity, propriety, and quality of the medical care furnished. These determinations will be made by medical professionals in accordance with 130 CMR 450.206. In addition, the Division may request review by the Massachusetts Chapter of the American Academy of Pediatrics, or other appropriate professional organization, for the purposes of making such determinations. This review will be considered before the Division proceeds with administrative action based on a determination of noncompliance with medical standards as defined in 130 CMR 450.204.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 18, § 10; M.G.L. c. 118E, § 4.

TN 95-17
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 5: 114.1 CMR 36.13(10)

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(l) Rates of payment for emergency services related to the Norplant System are established according to the methodology set forth in 114.1 CMR 36.13(8)(s).

(10) Classifications of Disproportionate Share Hospitals (DSHs) and Payment Adjustments The Medicaid program will assist hospitals who carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rates established under 114.1 CMR 36.13(10) to hospitals which qualify for such an adjustment under any one or more of the following classifications. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments is described in 114.1 CMR 36.13(10). Medicaid payment adjustments for disproportionate share contribute toward funding of allowable uncompensated care costs.

When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (114.1 CMR 36.13 (10) (a) through (e)). If a hospital's Medicaid contract is terminated, any adjustment will be prorated for the portion of the year during which it had a contract, the remaining funds it would have received will be apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals will be informed if an adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.13(10), a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a disproportionate share payment adjustment under 114.1 CMR 36.13(10) a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%.

The total amount of payment adjustments awarded to a particular public hospital under 114.1 CMR 36.13(10) will not exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and by uninsured patients, except as provided at 42 U.S.C. § 1396r-4(g).

(a) High Public Payer Hospitals: Disproportionate Share Status under St. 1991, c. 495.

1. Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.10 are eligible for this adjustment.
2. Calculation of Adjustment.

a. The Division of Medical Assistance will allocate $11.7 million for this payment adjustment.

b. The Commission will then calculate for eligible hospitals the ratio of their allowable free care charges, as defined in M.G.L. c. 118F, § 2, to total charges, for the period October 1, 1992 through September 30, 1993. The Commission will obtain allowable free care charge data from the Department of Medical Security.

c. The Commission will then rank the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 36.13(10)(a)2.b.

d. The Commission will then determine the 75th percentile of the ratios determined in 36.13(10)(a)2.b.

e. Hospitals who meet or exceed the 75th percentile will qualify for a High Public Payer Hospitals Adjustment. The Commission will multiply each qualifying hospital's FY93 allowable free care charges by the hospital's FY93 cost to charge ratio as of October 1, 1994, as calculated pursuant to 114.1 CMR 36.09 to determine allowable free care costs.

f. The Commission will then determine the sum of the amounts determined in 114.1 CMR 36.13(10)(a)2.e for all hospitals that qualify for a High Public Payer adjustment.

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g. Each hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.13(10)(a)2.a. multiplied by the amount determined in 114.1 CMR 36.13(10)(a)2.e. and divided by the amount determined in 114.1 CMR 36.13(10)(a)2.f.

(b) Basic Federally - Mandated Disproportionate Share Adjustment

1. The Commission will determine a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Commission will use the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Commission will determine and use the best alternative data source.

a. The Commission will use free care charge data from the Department of Medical Security.

b. The prior year RSC-403 report will be used to determine Medicaid days, total days, Medicaid inpatient net revenues, and total inpatient charges.

c. The hospital's audited financial statements for the prior year will be used to determine the state and/or local cash subsidy.

2. The Commission will calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Commission will determine such threshold as follows:

a. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This will be determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

b. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics. This will be determined according to the following formula:

$$\sqrt{\frac{\sum\left(\left(\frac{\text{total days}}{\text{average days}}\right) x \left(\frac{\text{Medicaid days}}{\text{total days}}\right)^2\right)}{N} - \left(\frac{\sum \text{Medicaid days}}{\sum \text{total days}}\right)^2}$$

Where N = number of hospitals, and average days = statewide sum of total days, divided by the number of hospitals.

c. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers will be the threshold Medicaid inpatient utilization rate.

d. The Commission will then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c., then the hospital will be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

3. The Commission will then calculate each hospital's low-income utilization rate as follows:

a. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

b. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

c. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.13(10)(b)3.a. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.13(10)(b)(3)b. If the low-income utilization rate exceeds 25%, the hospital

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will be eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

4. Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement will be calculated as follows:

a. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.13(10)(b), the Commission will divide the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.d. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

b. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Commission will divide the hospital's low-income utilization rate by 25%. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

c. The Commission will then determine, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)4.a. and 114.1 CMR 36.13(10)(b)4.b.

d. The Commission will then calculate a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.13(10)(b)5. by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)4.c.

e. The Commission will then multiply the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.13(10)(b)4.a. and b. The product of such multiplication will be the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

5. The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement will be $200,000 per year. These amounts will be paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.13(10)(b)4.e.

(c) Disproportionate Share Adjustment for Safety Net Providers. The Commission shall determine a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.13(10)(c)1. Through 3..

1. Data Sources. The Commission will use free care charge data from the Department of Medical Security, and total charges from the RSC-403. If the specified data source is unavailable, then the Commission shall determine and use the best alternative data source.

2. Eligibility ~~of Federally-Mandated Disproportionate Share Hospitals~~ for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is an additional payment for hospitals which meet the following criteria:

a. is a public hospital;

b. has a volume of Medicaid and free care charges in FY93 which is at least 15% of its total charges;

c. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;

d. has completed an agreement with the Division of Medical Assistance for intergovernmental transfer of funds to the Medicaid program for the disproportionate share adjustment for safety net providers;

e. is the subject of an appropriation authorizing an intergovernmental transfer.

* Secretary of State's technical error

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36.13: continued

3. Payment to ~~Federally Mandated Disproportionate Share~~ Qualifying Hospitals under the Adjustment for Safety Net Providers. The Commission will calculate an adjustment for hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.13(10)(c)2. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and shall equal the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers shall not be in effect for any rate year in which Federal Financial Participation under Title XIX is unavailable for this payment.

(d) Uncompensated Care Disproportionate Share Adjustment Hospitals eligible for this adjustment are those that report "free care costs," as defined by 117 CMR (Department of Medical Security (DMS)) and who are participating in the free care pool administered by the Department of Medical Security pursuant to M.G.L. c. 118F. The payment amounts for eligible hospitals are determined by the Department of Medical Security in accordance with its regulations at 117 CMR 7.00. These payments will be made to eligible hospitals in accordance with Department of Medical Security regulations and the ISA between the Division of Medical Assistance and the Department of Medical Security. Eligible hospitals will receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

(11) Data Sources. The following data sources are used in the development of the base costs per discharge: FY90 Medicaid paid claims file; the FY90 RSC-403 report, as submitted by hospitals to the Commission; and the FY90 Merged Casemix/Billing Tapes as accepted by the Commission. This data was supplemented by information from each hospital's FY90 year-end Maximum Allowable Cost (MAC) report and information from the intermediaries for the Medicare program, as needed. If a hospital's FY90 RSC-403 was not available, the hospital's FY89 RSC-403 was utilized. The "per review" version of the FY90 MAC report was used, if available. If it was not available, the FY90 "as filed" version was used.

The FY95 casemix index was calculated using the paid claims database for June 1, 1994 through May 31, 1995. This database is maintained by the Commonwealth's Division of Medical Assistance. The fiscal year 1994 RSC-403 cost reports as filed were used to develop rates of payment for organ acquisition, direct medical education, and malpractice costs. Hospital specific capital costs were taken from the FY92 Medicare Cost report (HCFA-2552). Data source used to develop the casemix-adjusted capital cost limit was the FY91 Medicare Cost report (HCFA-2552).

Administrative (AD) days used in the inpatient base calculation are obtained from the FY90 Medicaid claims data file. If the hospital's claims data had zero AD days or the AD days were less than 3% of its total hospital days, the FY90 RSC 404-A fourth quarter reported AD days were used for such hospitals.

(12) Upper Limit Review. Medicaid rates of payment calculated under the provisions of 114.1 CMR 36.13(12) shall conform to the upper limit requirement imposed by Title XIX of the Social Security Act. That is, the federal government requires that states certify that inpatient hospital payments in the aggregate do not exceed the amount of payments that would result if payments were based on the Medicare principles (TEFRA).

Rates of payment established pursuant 114.1 CMR 36.13(12) may be adjusted if it is determined that aggregate payments will exceed this limit or if adjustments are required by the Health Care Financing Administration (HCFA).

(13) Hospital Mergers Hospitals that have merged since fiscal year 1990 and have applied for and received a single Medicare and Medicaid provider number will be paid at a single weighted average standard payment per discharge rate, transfer, outlier, chronic and psychiatric *per diem* rate, and a weighted average PAF and cost to charge ratio. The weights shall equal each hospital's FY90 discharges as a proportion of total discharges for the merged hospitals. These weights will be applied to the inpatient rates as established by 114.1 CMR 36.13 which were calculated for each hospital to determine the single weighted average rate. The Administrative Day *per diem* rate will not be recalculated.

TN 95-17
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 6: 117 CMR 7.00